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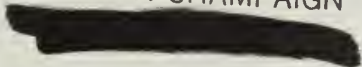
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PLANNING PAPER

81-004

THE SCOPE AND QUALITY OF PUBLIC
PARTICIPATION IN HEALTH PLANNING AGENCIES:
FINDINGS FROM A NATIONAL SURVEY
BY BARRY CHECKOWAY*



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THE SCOPE AND QUALITY OF
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INTRODUCTION

P.L. 93-641, The National Health Planning and Resources Development Act of 1974, provided an opportunity for health planning to "catch up" with the expanding citizen participation movements of recent years. It created a national network of Health Systems Agencies (HSA) and emphasized consumer participation in planning. In addition to "broadly representative" consumer majorities on HSA governing bodies, the law provided for public notice and open meetings, public hearings on plans, and a public record of board proceedings.¹ Surely citizens stood to benefit from methods that would provide representation, improve communication, and activate participation.

After five years, the record of participation in health planning is mixed. Top federal officials contend that the program has established a sound structure and developed plans involving citizens.² Others are more critical. Most analyses of participation under P.L. 93-641 have focused on the socially descriptive characteristics of consumer board members and other issues of representation, with the general findings that consumer board members are not always representative of their area's population or accountable to major constituency groups.³ Others have shown that there are serious obstacles to the expansion of consumer participation in planning, obstacles that are administrative in nature,⁴ that arise from disparities in knowledge among the



participants,⁵ or that result from the lack of consumer constituency support and community organization.⁶ There are studies of planning agencies that have sought participation with fervor,⁷ and of consumer groups that have organized around planning agencies and issues,⁸ but these cases by no means appear typical in the field. Although the literature on health planning is mounting, there as yet has been no comprehensive, systematic effort to inventory the status of participation on a national scale.

This paper reports on a national study designed to assess the scope and quality of participation in health planning agencies. The analysis is based on data drawn from responses to a mail questionnaire sent to a sample of agency officials responsible for public participation in HSAs across the nation. The survey was designed to inventory the objectives and methods in use, identify major participants and obstacles, and analyze impacts and factors influencing practice in the field. A total of 204 questionnaires was mailed to all HSAs in August, 1980, using a list provided by the Bureau of Health Planning. A response rate of 76 percent was achieved with 154 questionnaires returned by officials in states in all geographical sections of the country. Most were completed by the "public involvement" or "community education" specialist or by a person with similar title in each agency. These data are the best available source of information on this topic today.⁹

FINDINGS

Objectives of Participation. Federal legislation and administrative regulations prescribe broad rather than specific objectives

for participation in health planning. For example, federal performance standards direct HSAs to inform area residents to assure access to agency records and data, to provide a forum for expression of opinion, and to provide educational opportunities and activities.¹⁰ Some analysts consider broad objectives as a constraint on local practice, arguing that it is difficult to implement participation when statutory language and programmatic goals are vague.¹¹ Others contend that broad objectives provide an opportunity for motivated agencies to go beyond minimal compliance to innovative and exemplary methods.¹² Another school of thought argues the importance of adopting specific objectives as a basis for planning, implementation, and evaluation.¹³ And a number of analysts, who write with specific reference to health planning, argue for specific objectives that go beyond public information and public relations to political action in order to achieve concrete results, overcome opposition, and implement plans.¹⁴

The data presented in Table 1 indicate that agency officials have on the whole adopted broad rather than specific or political objectives for participation. Respondents cited as their primary objectives to provide information to citizens, to build support for the agency, to fulfill the federal mandate, and to improve agency decisions. These objectives are similar to those in the minimal federal mandates and they function to support program management without transfer of power to consumers. They suggest an "elite" model in which officials develop plans and then inform the general public.¹⁵ Arnstein argues that some citizens, traditionally peripheral to or excluded from the political

TABLE 1

OBJECTIVES OF PUBLIC PARTICIPATION
IN HEALTH PLANNING AGENCIES

(N=154)

Objectives	Very important	Somewhat important	Not too important	Not at all important
	Percentages ^a			
Provide information to citizens	76	23	1	b
Build support for the agency	70	28	2	b
Improve agency decisions	58	33	8	1
Fulfill the federal mandate	51	40	7	2
Involve low income and minority citizens	49	37	11	3
Collect information from or about citizens	38	49	13	6
Increase consumer control	32	45	18	4
Redistribute political power	11	39	40	11

^a Rounded to nearest whole number^b Less than one percent

arena, consider such objectives as forms of nonparticipation, aimed only to "inform" them, or to satisfy minimum requirements, or to allow them to advise without providing the power to decide.¹⁶ Despite some variations, the pattern is that agency officials, viewed overall, have not adopted a singular, driving objective for participation.

It is not surprising that agency officials have favored broad objectives that serve administrative ends without transfer of power. This is characteristic of planning agencies and federal programs with local variation that place emphasis on the values of efficiency, economy, and control. In the face of organized opposition and a recognized need for constituency support, however, one wonders if such an objective is long overdue.

Methods of Participation. Recent years have witnessed an increase in the scope of citizen participation methods available to planning agencies. A federal agency catalogue describes 37 current or emergent methods; an Advisory Commission on Intergovernmental Relations report analyzes more than 40 methods used by federal programs; and a publication of the Office of Consumer Affairs includes almost 100 case studies of successful consumer activities.¹⁷ Several analysts categorize selected methods according to function, such as information dissemination, consultation, decision-making, citizen control, and process support functions.¹⁸

The data shown in Table 2 indicate that a wide range of methods is used by HSAs. Although federal requirements specify a small number of methods in order to achieve minimal compliance, agency officials

TABLE 2

METHODS OF PUBLIC PARTICIPATION
USED BY HEALTH PLANNING AGENCIES

(N=154)

Method	Percent Used ^a
Distribute plans and reports to libraries and media	99
Legal notice of meetings in newspapers	99
Make records and data available upon request	99
Formal public hearings	99
Committees and task forces	99
Newsletter	97
Press releases to media	97
Informal meetings, forums, or workshops	97
Board orientation and training programs	97
Surveys of community needs	72
Subarea councils	56
Full-time staff assigned to subarea councils	57
Full-time staff assigned to consumers	46
Subarea field offices	29
Agency formation of consumer groups	16
Consumer board members caucus	13
Agency funding of consumer groups	5

^a Rounded to nearest whole number

indicate use of at least 30 methods encompassing a broad range and diverse functions. The most frequent methods employed are those that help satisfy minimal federal requirements, including formal public hearings (99%), legal notices of meetings (99%), newsletters (97%) and press releases (97%). Some analysts consider these to be "safe" methods that provide information and foster good public relations but do not always influence agency decisions or transfer power to consumers.¹⁹ Less frequent are methods that survey community needs (72%) or assign full-time staff to subarea advisory councils (57%) or to consumers (46%). More than half (56%) of the responding agencies employ subarea councils, which are often thought to decentralize power and program management to territorial subunits.²⁰ Only rarely were methods employed that provide a caucus of consumer board members (13%) or provide agency formation (16%) or funding (5%) of consumer groups. The relative infrequency of methods that focus on consumerism and consumer groups contrasts sharply with federal statements emphasizing consumer initiatives and seems to disregard studies that advocate consumer organization formation as a way to make health planning work.²¹

Agency officials were asked what they considered the most effective method of participation used by the agency. Respondents perceived subarea advisory councils (19%) as most effective, followed by newsletters (16%). Those with subarea councils were questioned regarding their use and generally found them important in constituency development, implementation, and training. Despite high satisfaction, however, subarea councils were employed by only 56 percent of the responding agencies and were never required by federal officials.

Public hearings also were singled out for focused analysis. Hearings are venerable American participation methods and are specifically required by health planning law. However, agency experience with public hearings, in contrast to subarea councils, appears mixed. Although most officials considered them a good way to learn public opinion (61%), most officials indicated that few people attend or participate in hearings (78%), that hearings tend to be dominated by providers (73%), and that consumers are not always effective participants in hearings (54%). Officials also indicated that hearings typically are advertised in the legal section of newspapers (91%), a strikingly ineffective way to inform the public about them. Nonetheless, hearings, unlike subarea councils, are required of all agencies.

Participants. P.L. 93-641 sought to broaden the base of participation in health planning, a field traditionally dominated by physicians, hospitals and other medical providers. But studies of consumer participation have shown that consumer board members do not generally represent their area's population, nor do they account to major constituency groups. Studies of provider representation have shown similarly that HSA provider board members are not representative of the overall provider workforce or the general population, and that HSAs in fact may be contributing to the further concentration of power among selected provider groups associated with traditional medical practice.²² Less is known about what Marmor and Morone call the "behavior" and "efficacy" of health planning representatives or about the community political arena in which health planning operates.²³

Agency officials were asked to indicate the types of people who participate in planning. The data presented in Table 3 show that a broad range of types of people take part as individuals in health planning, although some are more active than others. Hospital administrators and physicians are more active than all others, including other health care and social service providers and consumers. Less active are consumers of diverse types, including business and labor. Least active are low income citizens. While health planning appears to have broadened the base of participation, participation itself continues to be exercised in differential frequency among individuals, and traditional providers remain most active.

Agency officials also indicated the extent to which these types of people are organized into groups in the community. Group formation is a central factor for those seeking to participate in the planning political arena. The pattern of group formation resembles that of individual participation. While a broad range of participants tends to be organized in the local community, some are better organized than others. Physicians and hospital administrators are most likely, other provider and consumer groups less likely, and low income citizens least likely to be organized into groups in the community. This pattern contrasts with the usual image in which providers are perceived to have strong ongoing organizations while the general consumer public is broad, diffuse and lacking in organization. Instead, these data suggest that consumers also are organized, although less so than physicians and hospital administrators.

INDIVIDUAL AND GROUP PARTICIPATION IN HEALTH PLANNING AGENCIES

(N=154)

Types of People	Individual Participation			Organized into Formal Community Groups	Group Influence on Agency Decisions		
	Very active	Somewhat active	Not too active		Very influential	Somewhat influential	Not too influential
							Not at all influential
Percentages ^a							
Senior Citizens	40	44	16	88	13	53	30
Ethnic Minorities	25	41	31	67	15	46	32
Disabled/Handicapped	12	26	48	58	9	26	55
Women	62	33	5	58	20	42	33
Low Income	10	39	44	34	8	35	52
Physicians/Medical Society	81	16	3	97	62	33	4
Labor	17	35	35	81	13	36	39
Business/Chamber of Commerce	14	34	43	88	12	32	44
Insurers	33	46	18	62	21	58	19
Local Elected Officials	31	44	23	79	30	52	b
Nurses	51	37	12	84	18	55	26
Social Service Providers	30	52	16	63	11	62	26
Hospital Administrators	92	8	b	92	66	32	2

^a Rounded to nearest whole number

^b Less than one percent

Agency officials also indicated the extent to which these groups exercise influence on agency decisions. The pattern of group influence resembles that of individual participation. Respondents identified hospital administrators and physicians as most highly influential, other provider and consumer groups as less influential, and labor, business, and low income groups as least influential of all. These data support the usual image that traditional provider groups determine policy decisions and agency activities.

It is to be expected that physicians and hospital administrators are among the most active, best organized, and most influential individuals and groups in health planning. Their economic interests are narrow and concentrated enough to warrant disproportionate intervention and the effort required to dominate decisions. Provider dominance in planning, however, nullifies legislative and administrative efforts to change the pattern of provider dominance over health policy. Recent studies which suggest that providers have little commitment to health planning make their continued dominance of this field problematic.²⁴

It also comes as no surprise that low income people are among the least active, least organized, and least influential in health planning. Studies of planning agencies have shown that low income consumers are not represented on boards in proportion to their numbers in the population.²⁵ Other studies have shown that planning efforts at cost containment often worsen, rather than improve, the health services most needed by those with special access problems.²⁶ More general studies of the scope of participation in American society have

shown that low income citizens participate less in government programs even when these programs are presumably designed to elicit their participation.²⁷ Health planning has not reversed this pattern.

It is, however, surprising that business and labor are not more active or influential in health planning. As major purchasers of health care, these interests have an economic stake in controlling rising costs by becoming involved in planning.²⁸ As groups with political resources and ongoing organizations, they could provide powerful constituency support for planning agencies in the face of adversarial opposition.²⁹ Given their stake and needed support, one might have expected more active involvement.

These data further substantiate the image that health planning operates in an "imbalanced political arena" in which hospital administrators and physicians are more active, better organized, and more influential than other providers and consumers.³⁰ Health planning has involved these "others," but traditional providers carry on, perhaps better organized and more powerful than before P.L. 93-641.

Obstacles to Participation. Agency officials were asked to identify obstacles to participation in their agency from a list of possibilities. Their responses confirm previous studies. Most, in some cases nearly all, officials agreed that the general public does not perceive health planning as a community issue (89%), that agencies lack enough resources in terms of time or money (85%), that consumer board members lack adequate knowledge of health issues and planning (68%), that consumers are not well organized or a force in the community

and commitment to participation, a result that contrasts sharply with previous studies that have characterized staff as unreceptive to consumer initiatives and lacking a sense of consumer priorities.³¹ Instead, officials saw themselves as trained and experienced (80%), and their executive director as committed (84%), but working in the face of serious obstacles.

It is of note that while agency officials perceived several obstacles to public participation, there were contradictions between the obstacles they perceived and the actual participation objectives and methods they chose. For example, while officials perceived legislative mandates as vague, they themselves have not focused their local objectives; while they identified the lack of consumer organization as an obstacle, they tended not to perceive increased consumer control as an important objective. For example, they have not provided significant resources to consumers or formed or funded consumer organization.

Quality of Participation. The increase in federal mandates for citizen participation has not significantly increased the ability to evaluate the effectiveness of such participation.³² On the contrary, only a few evaluation studies focus on the effectiveness of participation. Those few studies tend to take the stated aims for granted and evaluate particular methods in terms of their frequency and number. Thus, it is common to claim that because a method aims to involve citizens, and because proceedings are held and people attend and express views, that participation must necessarily have taken place. But an extensive gap may separate stated aims and actual practice, and the number of

proceedings held or the number of people who take part in them are not a complete measure of their quality. Although most analytic discussion centers on the scope of participation, quality may be its most important attribute. According to Kasperson and Breitbart, participation quality is "effective" if it influences a decision or produces a policy outcome.³³ Yet little is known about the quality or impact of many major methods employed.

In the present study, agency officials were asked to indicate the extent to which participation had influence or impact on health planning. The data shown on Table 4 indicate that officials gave a mixed response in assessing the impact of participation on the implementation of substantive health policy goals. They agreed that participation has improved the quality (75%) and accessibility (92%) of local health services, but were less certain about whether participation had improved health status (46%) and contained rising cost (55%). Officials also gave mixed responses in assessing the impact of participation on the individuals involved in health planning. Many (69%) believed that participation had developed consumer leadership and confidence but disagreed (46%) over whether it had helped consumers emerge as a political force on issues of health. Officials were more uniformly agreed in assessing the impact of participation on the planning procedures and the process by which agency decisions are made, strongly agreeing (87%) that participation had made planning more responsive to consumer needs. Most claimed that it increased the flow of information to and from the agency (80%), raised public

TABLE 4

EFFECTIVENESS OF PARTICIPATION
ON HEALTH PLANNING AGENCIES

(N=154)

Measures of Effectiveness	Very much	Somewhat	Very little	Not at all
	Percentages ^a			
Made health planning more responsive to consumer needs?	29	59	12	b
Increased the flow of information to/from the agency?	21	60	20	b
Increased the power of hospital administrators and physicians/	6	17	59	17
Helped consumers emerge as a political force on issues of health?	5	44	39	12
Developed consumer leadership and confidence?	13	57	27	4
Improved the health status of the population?	2	44	42	12
Contained the rising cost of local health services?	4	51	38	7
Improved the quality of local health services?	4	71	18	7
Increased the accessibility of local health services?	11	70	17	1
Increased conflict and divisions in the community?	3	24	53	21
Raised public awareness of health issues and planning?	18	66	14	2
Developed constituency support for the agency?	12	65	22	2

^a Rounded to nearest whole number^b Less than one percent

awareness of health issues and planning (84%), and developed constituency support for the agency (76%).

Although these data suggest that agency officials perceive that public involvement has had influence or impact, data from other sections of the questionnaire suggest that problems remain. Thus while 87 percent of the agency officials perceived that public involvement has made health planning more responsive to consumer needs, 69 percent agreed that providers dominate policy and planning. While 80 percent perceived that public involvement has increased the flow of information to and from the agency, 83 percent agreed that the general public does not perceive health planning as a community issue. While 49 percent believed public involvement has helped consumers emerge as a political force, and 70 percent believed it has developed consumer leadership and confidence, 82 percent agreed that consumers are not a well organized force in the community, and most perceived physicians and hospitals as the most active, best organized, and strongest influence on agency decisions. In short, while agency officials perceived that public involvement has had impact or influence, they also acknowledged that serious problems remain.

CONCLUSION

Today the future of participation in health planning is in question. The conservative Reagan administration promises less money for domestic programs, and HSAs may be among the first agencies to go. Federal officials are responding to administration proposals to dismantle

federal health planning programs by describing the accomplishments of planning and participation. One official lauds the formation of a national network of HSAs that have produced health systems plans and involved thousands of participating citizens who "invested a large amount of time and energy to tailor a national policy to their local needs."³⁴ Another argues that health planning is "impossible to evaluate" but that "anecdotes, observations, and informed guesses" indicate that health planning has operated as a "community trusteeship" that has "boosted local voluntarism," "raised public consciousness," and made a new social institution "accessible to the concerned lay person."³⁵ Their image seems to be that since HSAs were established and developed plans according to federal guidelines, then participation must necessarily have taken place.

This paper suggests something different about consumer participation in health planning under P.L. 93-641. It does not question that health planning agencies have been established and developed plans according to federal guidelines, or that a number of participation proceedings have been held and a number of people have taken part in them, or that the awareness, knowledge and capacity of some citizens have been increased, or that health planning in some cases has been made more responsive to consumer needs. Some health planning agencies have taken a step toward participation, and participation has had uses for some citizens. All this is easily confirmed in the literature.

This paper does challenge those who would make claims about the scope of participation from the number of proceedings that have been

held and the number of people who have taken part in them, or who would infer the quality of participation from the formation of planning agencies and the production of plans. It questions evaluations of the performance of a major national program that are based on anecdotes, observations, and informed guesses alone, and it challenges those who fail to emphasize that while HSAs have improved awareness and activated some participation, there still are serious gaps between stated participation aims and actual practice. There is abundant evidence that the traditional pattern of provider dominance and consumer subservience has been intensified under P.L. 93-641. Exceptional HSAs have sought participation with fervor, but most have not adopted singular, driving objectives for participation and instead have favored "safe" participation methods that satisfy minimum federal requirements and provide information and public relations without transfer of power to consumers. Most agencies have helped broaden the base of participation in planning, but without mobilizing consumers or reducing the dominance of providers. Exceptional consumers and consumer groups have increased in number and capacity around health planning agencies, but providers remain the most active, best organized, and influential participants. Agency officials view themselves as trained, experienced, and committed, but they work in the face of serious internal and external obstacles, and major problems of participation still remain.

1. 0.3 1

2. 0.3 1

NOTES

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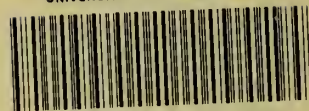
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20. Kasperson and Breitbart, op. cit., argue that many methods thought to "decentralize" power are actually methods of "deconcentration" or new forms of centralization.
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